

The National Policy for Emergency in Brazil

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Commentary

Brazil is a country of continental dimensions, with approximately 200 million people and which chose to institute the universal right to health at the end of the 80s [1].

The Unified Health System (SUS) lives since then with a robust private health care, heavily subsidized by public funds and serves approximately 25% of the population.

This double supply of health systems produced a SUS with serious structural deficits and financing. By the early 2000s access to the SUS occurred primarily through primary care units and emergency departments. The shortage of intermediate complexity and diagnostic - therapeutic units of specialty services increased the demand on hospital emergency services, generating an enormous wear and dissatisfaction of the population with these services

In this scenario, the urgency of policy becomes a priority for the country in early 2000. It can be said that the implementation of federal policy for attention to the emergency room in Brazil involved three main stages: until 2003 there is a predominance of the rules [2]; between 2004 and 2008 there is a great expansion of the Mobile Emergency Service (SAMU); and from 2009 dominates the fixed component of the implementation of pre-hospital care, the Emergency Care Units (APU). The fourth period begins in 2011, when, in accordance with federal guidelines conformations of health care networks are proposed to the Emergency Care Network in order to integrate emergency services [3].

The SAMU, the first component to be deployed, attended a healthcare mobile empty attention to the emergency room in the country, which until then was partially met by the corporation of Military Fire without health team, making only the rescue and transport of the victim. The SAMU caters to people at home or public roads through a unified phone number in the country. The service is coordinated by a Regulatory Medical Center and basic ambulances are sent (staff with nursing technicians and with less technological resources) or advanced ambulance (with doctor and nurse on staff and superior technological resources), as the case requires [4].

The SAMU has been a structuring strategy of the emergency service in Brazil. Currently coverage is 75% of the population, with 100% coverage expectations by 2018. Some studies in the country highlight positive results from the implementation of SAMU, although still scarce production of national studies [5].

The Emergency Unit (UPA) comprises the fixed component of pre-hospital care. It should be integrated into primary care and a hospital network reference. Currently there are 398 UPA in the country and is planned to build 889 more across the country by 2018. The implementation of these units increased the population's access to emergency services, however caused bottlenecks for access to the hospital bed. These units have been consistent patients for more than 24 hours despite not having resources for hospitalization [6]. Recent national survey found that most UPA are in cities with over 1 million inhabitants, followed by municipalities with populations between 500,000 and 1 million and that privileged regions with better

socioeconomic and service provision conditions, such as Southeast (CONASS, Ibanez, 2015). Note that the PSUs are the result of an initiative of the state of Rio de Janeiro that has been a pioneer in pre-hospital care since the year 1980. The structural constraints and institutional policy that allowed this initiative are well described in recent research on attention pre-hospital fixed in the state [7].

The hospitals available to the NHS are the most undersized. Brazil has an aging hospital network [8], consisting primarily of general hospitals, small to medium size of, who do care to acute, to elective and chronic indistinctly. Hospitals with less than 50 beds (Small Hospitals Porte - HPP) make up 63.7% of the total and 50-100 beds 18.5%. The hospitals of 101 beds or more accounted for 17.8% of the country's hospitals in 2014. In the emergency hospital policy response capacity is limited to an insufficient quantity of the country's hospitals [9], with more beds and more effective by concentrating more resources and provide care of greater complexity. These hospitals live with overcrowded emergency. This overcrowding was very well analyzed under the managerial and sociological point of view, however, despite the extensive international literature on the subject, in the country there is still a gap in the analysis of overcrowding in emergency departments [10].

The provision of NHS beds in 2005 was 353 163 beds and in 2014 was 315,894, a decrease of 37,269 beds (10.5%). In fact, citizens with different needs compete among themselves about 1.5 beds per 1,000 inhabitants offered by SUS. Some qualification strategies and increasing the number of hospital beds has been conducted, but to date there has been a favorable change of hospital care panorama in the country.

The federal government has responded to the problem of meeting the emergency/medical emergencies in the SUS, but there was a small investment to pre-hospital care to date. The urgency of policy to fight the problem is new on the national scene, studies should be conducted to assess the impact of these investments [11].

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